		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0030411

Facility Name: Sunshine Manor Nursing Center

Address: 751 North Oak Street (Number) Carlinville (City) 62626 (Zip Code)

County: Macoupin

Telephone Number: (217)854-2511 **Fax #** (217) 854-4377

IDPA ID Number: 51-0271905

Date of Initial License for Current Owners: 10/1/85

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Karl Baker, BKD LLP **Telephone Number:** (314) 231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Chad Butterfield, THCSLLC, Mgt. Co. for
(Title) Sunshine Manor

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title)
(Firm Name & Address)
(Telephone) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	98	Skilled (SNF)	98	35,770	1
2	0	Skilled Pediatric (SNF/PED)	0	0	2
3	0	Intermediate (ICF)	0	0	3
4	0	Intermediate/DD	0	0	4
5	0	Sheltered Care (SC)	0	0	5
6	0	ICF/DD 16 or Less	0	0	6
7	98	TOTALS	98	35,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	1,775	60	2,875	4,710	8
9	SNF/PED	0	0	0		9
10	ICF	10,787	9,804	296	20,887	10
11	ICF/DD	0	0	0		11
12	SC	0	0	0		12
13	DD 16 OR LESS	0	0	0		13
14	TOTALS	12,562	9,864	3,171	25,597	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 71.56%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
N/A

F. Does the facility maintain a daily midnight census? Y

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 10/1/85

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 10/1/85 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 2,776

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 6/30 Fiscal Year: 6/30

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger: Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	115,306	6,984	5,855	128,145		128,145	(3,611)	124,534			1
2	Food Purchase		106,483		106,483		106,483	(357)	106,126			2
3	Housekeeping	54,197	8,222		62,419		62,419		62,419			3
4	Laundry	53,295	8,779	43	62,117		62,117		62,117			4
5	Heat and Other Utilities			69,221	69,221		69,221		69,221			5
6	Maintenance	33,640	6,068	26,450	66,158		66,158		66,158			6
7	Other (specify):*			2,139	2,139		2,139		2,139			7
8	**TOTAL General Services**	256,438	136,536	103,708	496,682		496,682	(3,968)	492,714			8
	B. Health Care and Programs											
9	Medical Director			16,033	16,033		16,033		16,033			9
10	Nursing and Medical Records	787,047	65,645	4,654	857,346		857,346		857,346			10
10a	Therapy		437	98,609	99,046		99,046		99,046			10a
11	Activities	34,789	3,729	3,171	41,689		41,689		41,689			11
12	Social Services	28,977	311	2,573	31,861		31,861		31,861			12
13	Nurse Aide Training					215	215		215			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	850,813	70,122	125,040	1,045,975	215	1,046,190		1,046,190			16
	C. General Administration											
17	Administrative	54,464	(112)		54,352		54,352		54,352			17
18	Directors Fees											18
19	Professional Services			173,119	173,119		173,119	10,665	183,784			19
20	Dues, Fees, Subscriptions & Promotions			48,314	48,314		48,314	(35,945)	12,369			20
21	Clerical & General Office Expenses	66,068	14,715	53,414	134,197		134,197	(38,496)	95,701			21
22	Employee Benefits & Payroll Taxes			166,375	166,375		166,375	3,972	170,347			22
23	Inservice Training & Education			1,161	1,161	(215)	946		946			23
24	Travel and Seminar			4,714	4,714		4,714	884	5,598			24
25	Other Admin. Staff Transportation			4,891	4,891		4,891		4,891			25
26	Insurance-Prop.Liab.Malpractice			71,871	71,871		71,871	1,589	73,460			26
27	Other (specify):*											27
28	**TOTAL General Administration**	120,532	14,603	523,859	658,994	(215)	658,779	(57,331)	601,448			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,227,783	221,261	752,607	2,201,651		2,201,651	(61,299)	2,140,352			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Sunshine Manor Nursing Center #0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			126,570	126,570		126,570	13	126,583			30
31	Amortization of Pre-Op. & Org.			12,733	12,733		12,733	(12,733)				31
32	Interest			468,813	468,813		468,813	(32,363)	436,450			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			2,154	2,154		2,154		2,154			35
36	Other (specify):*											36
37	**TOTAL Ownership**			610,270	610,270		610,270	(45,083)	565,187			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,193	39,401	106,594		106,594		106,594			39
40	Barber and Beauty Shops			1,085	1,085		1,085	(1,134)	(49)			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			53,655	53,655		53,655		53,655			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		67,193	94,141	161,334		161,334	(1,134)	160,200			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,227,783	288,454	1,457,018	2,973,255		2,973,255	(107,516)	2,865,739			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(3,236)	1		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients		39		7
8	Laundry for Non-Patients		4		8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	(32,363)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		32		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)		2		16
17	Non-Care Related Fees				17
18	Fines and Penalties		25		18
19	Entertainment				19
20	Contributions	325	21		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(50)	21		24
25	Fund Raising, Advertising and Promotional	(35,945)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(2,060)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (73,329)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense	(12,733)	31	33
34	Adjustments for Related Organization Costs (Schedule VII)	(21,454)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (34,187)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (107,516)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Sunshine Manor Nursing Center

ID# 0030411

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Vendor Income	$ (375)	1	1
2	Barber and Beauty Revenue	(1,134)	40	2
3	Extraordinary Income/(Expense)			3
4	(Gain)/Loss on Sale of Assets	0	30	4
5	Miscellaneous (Income)/Expense	(207)	21	5
6	Adjust Depreciation Expense to Schedule XI	13	30	6
7	Raw foods rebate	(357)	2	7
8	Adjust R/E taxes to actual	0	33	8
9	Offset Bank Fees			9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(2,060)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	(3,611)	0	0	0	0	0	0	0	0	0	0	(3,611)	1
2	Food Purchase	(357)	0	0	0	0	0	0	0	0	0	0	(357)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(3,968)	0	0	0	0	0	0	0	0	0	0	(3,968)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	10,665	0	0	0	0	0	0	0	0	0	10,665	19
20	Fees, Subscriptions & Promotions	(35,945)	0	0	0	0	0	0	0	0	0	0	(35,945)	20
21	Clerical & General Office Expenses	68	(38,564)	0	0	0	0	0	0	0	0	0	(38,496)	21
22	Employee Benefits & Payroll Taxes	0	3,972	0	0	0	0	0	0	0	0	0	3,972	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	884	0	0	0	0	0	0	0	0	0	884	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	1,589	0	0	0	0	0	0	0	0	0	1,589	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(35,877)	(21,454)	0	0	0	0	0	0	0	0	0	(57,331)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,845)	(21,454)	0	0	0	0	0	0	0	0	0	(61,299)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Sunshine Manor Nursing Center** **#** **0030411** **Report Period Beginning:** **07/01/00** **Ending:** **06/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	13	0	0	0	0	0	0	0	0	0	0	13	30
31	Amortization of Pre-Op. & Org.	(12,733)	0	0	0	0	0	0	0	0	0	0	(12,733)	31
32	Interest	(32,363)	0	0	0	0	0	0	0	0	0	0	(32,363)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(45,083)	0	0	0	0	0	0	0	0	0	0	(45,083)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	(1,134)	0	0	0	0	0	0	0	0	0	0	(1,134)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(1,134)	0	0	0	0	0	0	0	0	0	0	(1,134)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(86,062)	(21,454)	0	0	0	0	0	0	0	0	0	(107,516)	45

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
		See Attached listing				

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	5	Heat and Other Utilities	$	MidAmerica Care Foundation	100.00%	$	$	1
2	V	19	Professional Services		MidAmerica Care Foundation	100.00%	10,665	10,665	2
3	V	21	Clerical & Other General Office	39,299	MidAmerica Care Foundation	100.00%	735	(38,564)	3
4	V	24	Travel and Seminar		MidAmerica Care Foundation	100.00%	884	884	4
5	V	26	Insurance		MidAmerica Care Foundation	100.00%	1,589	1,589	5
6	V	32	Interest Expense		MidAmerica Care Foundation	100.00%			6
7	V	35	Rent-Equipment		MidAmerica Care Foundation	100.00%			7
8	V	22	Employee Benefits		MidAmerica Care Foundation	100.00%	3,972	3,972	8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 39,299			$ 17,845	$ * (21,454)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1									$		1
2	Not Applicable										2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: MidAmerica Care Foundation
Street Address: 7611 State Line Road, Suite 301
City / State / Zip Code: Kansas City, Missouri 64114
Phone Number: (816) 444-0900
Fax Number: (816) 822-8799

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	Heat and Other Utilities	Patient Days	325,461	13	$ 0	$	25,597	$ 0	1
2	19	Professional Services	Patient Days	325,461	13	135,609		25,597	10,665	2
3	21	Clerical & Other General Office	Patient Days	325,461	13	9,341		25,597	735	3
4	24	Travel and Seminar	Patient Days	325,461	13	11,236		25,597	884	4
5	26	Insurance	Patient Days	325,461	13	20,200		25,597	1,589	5
6	32	Interest Expense	Patient Days	325,461	13	0		25,597	0	6
7	35	Rent-Equipment	Patient Days	325,461	13			25,597	0	7
8	22	Employee Benefits	Patient Days	325,461	13	50,500		25,597	3,972	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 226,886	$		$ 17,845	25

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	Carlinville Class 6(E) Bonds		X	Mortgages	Varies	31048	$ 3,700,000	$ 3,860,485	11/01/15	12.00%	$ 463,258	1
2	Macoupin County Treasurer		X	Past Due R/E Taxese	Varies	33329	74,958		04/01/06	9.00%	6,635	2
3							3,194	4,416			(1,080)	3
4												4
5												5
	Working Capital											
6	Interest Income		X								(32,363)	6
7												7
8												8
9	TOTAL Facility Related						$ 3,778,152	$ 3,864,901			$ 436,450	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 3,778,152	$ 3,864,901			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2000 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Sunshine Manor Nursing Center COUNTY Macoupin

FACILITY IDPH LICENSE NUMBER 0030411

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	Not Applicable		$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 25,000 B. General Construction Type: Exterior Brick and block Frame _____ Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [X] YES [ ] NO
If so, please complete the following:

1. Total Amount Incurred: 393,020
2. Number of Years Over Which it is Being Amortized: Various
3. Current Period Amortization: 12,733
4. Dates Incurred: Various

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$	1
2					2
3	TOTALS			$	3

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	98		85	75	$ 2,603,743	$ 86,791	30	$ 86,791	$ 0	$ 1,359,732	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Improvements 1986			86	200,948	6,798	29	6,929	131	103,242	9
10	Improvements 1987			87	2,931	154	15	195	41	2,826	10
11	Improvements 1990			90	7,589	632	12	632	(0)	7,009	11
12	Improvements 1991			91	87,447		7			86,821	12
13	Improvements 1992			92	9,887		7			9,887	13
14	Improvements 1993			93	32,582	623	7		(623)	32,582	14
15	Improvements 1994			94	25,815	2,787	10	2,582	(206)	20,982	15
16	Improvements 1995			95	38,667	3,158	12	3,222	64	18,969	16
17	Improvements 1996			96	34,955	3,005	12	2,913	(92)	13,825	17
18	Kohler Hopper			97	800	27	30	27	(0)	118	18
19	3 - Ton Air Conditioning Unit			97	2,903	97	30	97	0	419	19
20	Handrails			97	3,967	264	15	264	0	1,102	20
21	Fire Door			97	620	41	15	41	0	172	21
22	Drapery			97	1,836	122	15	122	0	500	22
23	Windows for Dining Room			96	2,049	68	30	68		319	23
24	Windows for Dining Room			96	4,163	139	30	139	(0)	648	24
25	PT & Activity Remodel			97	6,500	217	30	217	(0)	957	25
26	Carpeting for Offices			97	2,442	244	10	244	(0)	1,079	26
27	Tiling Dining and Living Rooms			97	9,900	990	10	990		4,125	27
28	Garage			97	7,390	246	30	246	0	1,026	28
29	Wall Paper			97	3,556	119	30	119	0	484	29
30	Fire Wall			97	1,446	72	20	72		289	30
31	Wall Paper			98	5,357	357	15	357	0	1,012	31
32	Ceiling Tile			99	1,396	93	15	93	(0)	196	32
33	Fire Control Panel			99	1,840	123	15	123	(0)	256	33
34	Interior Signage			99	3,221	215	15	215	0	429	34
35	Compressor - Rooftop			99	1,150	77	15	77	(0)	153	35
36	Flow Protection			99	3,620	241	15	241		442	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Electric Heater	99	$ 5,559	$ 556	10	$ 556	$ 0	$ 1,019	37
38	Landscaping	98	1,607	161	10	161	(0)	496	38
39	Converter on generator	97	1,118	160	7	160	(0)	639	39
40	Sealing of Parking Lots (2)	2000	2,060	172	12	172	(0)	172	40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 3,119,064	$ 108,750		$ 108,065	$ (684)	$ 1,671,928	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 238,164	$ 17,327	$ 17,392	$ 65	Varies	$ 161,187	71
72	Current Year Purchases	11,260	493	1,126	633	10	493	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 249,424	$ 17,820	$ 18,518	$ 698		$ 161,680	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 3,368,488	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 126,570	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 126,583	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 13	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,833,609	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92	CIP #1142	$ 5,879	92
93			93
94			94
95		$ 5,879	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 2,154 Description: See Attached Detail
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- COMMUNITY COLLEGE [ ]
- HOURS PER AIDE ____

3. CLINICAL PORTION:
- IN-HOUSE PROGRAM [ ]
- IN OTHER FACILITY [ ]
- HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$ 215	$	$	$ 215
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$ 215	$	$	$ 215
10	SUM OF line 9, col. 1 and 2 (e)	$ 215			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	9
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	9

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	775	$	33,883	$	775	$ 33,883	1
2	Licensed Speech and Language Development Therapist		hrs		100		6,084		100	6,084	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		1,339		58,639		1,339	58,639	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	2,214	$	98,606	$	2,214	$ 98,606	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 06/30/01 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 671,730	$	1
2	Cash-Patient Deposits	1,000		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	197,128		3
4	Supply Inventory (priced at)	13,967		4
5	Short-Term Investments			5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	795		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 884,620	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	3,097		13
14	Buildings, at Historical Cost	3,081,316		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	289,951		16
17	Accumulated Depreciation (book methods)	(2,046,451)		17
18	Deferred Charges	393,020		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):	4,526		22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,725,459	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,610,079	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 49,382	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	3,711,180		29
30	Accrued Salaries Payable	73,013		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other liab.'s and Patient Trust Dep	14,712		36
37	Due to affiliates	1,498		37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 3,849,785	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	4,416		39
40	Mortgage Payable	3,860,485		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 3,864,901	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,714,686	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (5,104,607)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,610,079	$	48

***(See instructions.)**

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (4,777,436)	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (4,777,436)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(327,171)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (327,171)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (5,104,607)	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 3,100,329	1
2	Discounts and Allowances for all Levels	(869,656)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 2,230,673	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	390,629	6
7	Oxygen	1,954	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 392,583	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	375	12
13	Barber and Beauty Care	1,134	13
14	Non-Patient Meals	3,236	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 4,745	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	32,363	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 32,363	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Extraordinary Income/Loss & Misc.	(14,280)	28
28a	G/L on Sale of Asset		28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ (14,280)	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,646,084	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	496,682	31
32	Health Care	1,045,975	32
33	General Administration	658,994	33
	B. Capital Expense		
34	Ownership	610,270	34
	C. Ancillary Expense		
35	Special Cost Centers	107,679	35
36	Provider Participation Fee	53,655	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,973,255	40
41	**Income before Income Taxes (line 30 minus line 40)****	(327,171)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (327,171)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? YES If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	4,147	4,491	$ 81,234	$ 18.09	1
2	Assistant Director of Nursing	0	0	0		2
3	Registered Nurses	8,703	9,113	143,843	15.78	3
4	Licensed Practical Nurses	8,355	8,749	111,000	12.69	4
5	Nurse Aides & Orderlies	49,327	51,663	438,397	8.49	5
6	Nurse Aide Trainees	0	0	0		6
7	Licensed Therapist	0	0	0		7
8	Rehab/Therapy Aides	0	0			8
9	Activity Director	3,918	4,173	34,789	8.34	9
10	Activity Assistants	0	0	0		10
11	Social Service Workers	3,548	3,582	28,977	8.09	11
12	Dietician	0	0	0		12
13	Food Service Supervisor	0	0	0		13
14	Head Cook	0	0	0		14
15	Cook Helpers/Assistants	15,755	16,632	115,306	6.93	15
16	Dishwashers	0	0	0		16
17	Maintenance Workers	2,082	2,302	33,640	14.61	17
18	Housekeepers	8,808	9,233	54,197	5.87	18
19	Laundry	6,663	7,049	53,295	7.56	19
20	Administrator	2,092	2,181	54,464	24.97	20
21	Assistant Administrator	0	0	0		21
22	Other Administrative	0	0	0		22
23	Office Manager	0	0	0		23
24	Clerical	5,983	6,240	66,068	10.59	24
25	Vocational Instruction	0	0	0		25
26	Academic Instruction	0	0	0		26
27	Medical Director	0	0	0		27
28	Qualified MR Prof. (QMRP)	0	0	0		28
29	Resident Services Coordinator	0	0	0		29
30	Habilitation Aides (DD Homes)	0	0	0		30
31	Medical Records	1,572	1,639	12,573	7.67	31
32	Other Health Care(specify)	0	0	0		32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	120,953	127,047	$ 1,227,783 *	$ 9.66	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	136	$ 5,855	line 1, col 3	35
36	Medical Director	220	16,033	line 9, col 3	36
37	Medical Records Consultant	24	1,080	line 10, col 3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	88	3,574	line 10, col 3	39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	48	2,485	line 11, col 3	44
45	Social Service Consultant	47	2,573	line 12, col 3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	563	$ 31,600		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$ 0	Ln 10, Col 1	50
51	Licensed Practical Nurses		0	Ln 10, Col 1	51
52	Nurse Aides		0	Ln 10, Col 1	52
53	TOTAL (lines 50 - 52)		$		53

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XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Robertson, Janet	Administrator		$ 54,464
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 54,464

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Various	Purch Serv	$ 151
Tutera Health Care Mgt	Management Fees	150,984
Various	Legal Fees	2,470
Various	Accounting Fees	3,392
Various	D/P Fees	8,669
Various	Professional Serv	3,048
Various	Trustee Expenses	4,405
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 173,119

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 45,371
Unemployment Compensation Insurance	23,078
FICA Taxes	76,123
Employee Health Insurance	19,843
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Other Benefits	1,960
Home Office Allocation	3,972
TOTAL (agree to Schedule V, line 22, col.8)	$ 170,347

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 186
Advertising: Employee Recruitment	1,221
Health Care Worker Background Check	4,679
(Indicate # of checks performed 960)	
Contributions	325
Dues & Subscriptions	5,958
Advertising PR & Other	35,945
Reclassifications	
Less: Public Relations Expense	( )
Non-allowable advertising	(35,945)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,369

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	4,714
Home Office Allocation	884
Seminar Expense	
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,598

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Sunshine Manor Nursing Center # 0030411 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Sunshine Manor Nursing Center **#** 0030411 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? N

(2) Are there any dues to nursing home associations included on the cost report? Y
If YES, give association name and amount. IHCA, $4,186

(3) Did the nursing home make political contributions or payments to a political action organization? N If YES, have these costs been properly adjusted out of the cost report? N/A

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? Y If YES, what is the capacity? 94

(5) Have you properly capitalized all major repairs and equipment purchases? Y
What was the average life used for new equipment added during this period? 7

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 18,899 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Y If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? N
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES N NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO N If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 53,655
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? N If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Y

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? N For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 0 Has any meal income been offset against related costs? Y Indicate the amount. $ 3,236

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? N
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? N If YES, please indicate the amount of income earned from such a program during this reporting period. $ 0
c. What percent of all travel expense relates to transportation of nurses and patients? 0%
d. Have vehicle usage logs been maintained? N/A
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? N/A
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Y
g. Does the facility transport residents to and from day training? N
Indicate the amount of income earned from providing such transportation during this reporting period. $ 0

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: BKD, LLP - KC The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? N If no, please explain. Not Complete

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Y

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? n
Attach invoices and a summary of services for all architect and appraisal fees.